Accident / Incident Report Closed

Unit/Department	Process Area	Site	Report Number
South Operation-Elyria	**General Catalyst – Building 31**	**ELYRIA**	**0084-SOPS-16-0009**
Report Date	Incident Date	Incident Time	Copied From
01/13/2016	**01/13/2016**	**10:00 AM**	
Incident Location		Team Leader / Supervisor	Reported By
Calciner #1 Hopper		**Andrew Myers**	**Andrew Myers**
Title of Event (Limit to 90 characters)		Category	Division / Bus. Group / Subgroup Code
NOx Release Out of #1 RC Hopper		☐ Safety & Health ☐ Environmental	**CC / G-CCP**

Incident Classification

☐ Near Miss	☐ Property Loss	☐ Contractor
☐ Process Safety	☐ Citation / NOV	☐ Contractor Injury / Illness
☐ Injury / Illness	☐ Health Exposure	☐ Contract Injury / Illness
☒ Spill / Release	☐ Inspection	☐ PSM
☐ Permit / Regulatory Deviation	☐ Major Incident	☐ Plant Upset
☐ Fire	☐ Non-Occupational	☐ EHS Management System Failure
☐ Odor Complaint	☐ RMP	☐ Other

Describe Event / What Happened

The Calciner hopper ran empty and the slide gate was not closed. This led to NOx back feeding the up through the hopper and out into the department. The operator who is not usually on the calciners thought that the feed rate on the DCS was based off the syntron and not the scale and therefore though there was more left to feed.

Immediate Corrective Action or Response

Closed Slide gate. Did Air Monitoring in area. Opened roll up door for fresh air intake.

Immediate Cause

Slide gate was left open by operator after the sock went empty.

Spill Release Type(s)	**Non RQ Spill / Release**

Chemical(s) Involved	CAS #	Phy. State	Air	Land	Water	Contmt	Units
Nitrogen Dioxide (NOx)	10102-44-0	Gas	.1	0	0	0	lbs

Disposition of Material	**Air from #1 Hopper**			
Weather Conditions	Skies:	Temperature:	Wind Direction:	Wind Speed:

Cause Narrative

An operator who was not usually on the calciners was looking at the discharge rate and thought it was the feed rate. He therefore thought the calciner was still feeding at 400# an hour and the hopper had not gone empty. This led to him allowing him sock to go completely empty which allows for NOx to go out into the department.

Contributing Causes	Root/Primary Causes		
Operator thought the calculation based on the scale weight was actually the feed rate which allowed the hooper to go empty. Operator was not specifically told to keep his eye on the sock and not the feed rate.	192 - Communications	200 - Misunderstood Communication	201 - Standard Terminology Not Used
The current design relies on operators to know exactly when to close the valve to prevent a possible excursion. No instrumentation is used to close the manual gate	15 - Design Input/Output	16 - Design Input LTA	16 - Design Input LTA

Any known or potential off-site impacts?	No	PSM Incident?	No	Estimated Cost:	2,000.00 USD
Investigation Team	Brian Beller; Andrew Myers				

Item	Corrective Action(s) to prevent recurrence	Responsible Person	Target Date	Final Closed Date	VC Req	VE Req
1	Communicate event in the safety meeting and explain the importance of watching the sock.	Douglas Stock/NA/BASF	05/31/2016	03/31/2016	N	N
2	Investigate automating the valve at the claciner along with a method to close the valve at the time the feed runs empty	Kirk Sullenberger/BASF-CATALYSTS/BASF	09/08/2016	09/08/2016	N	N

Approved By:	
Manager / Dept. Head	**Leon Zavodnik 02/08/2016 08:15 PM**
EHS Unit Coordinator	**Valerie Douglas 02/12/2016 03:01 PM**
Safety & I.H.	**Nancy Gallagher 02/12/2016 11:43 AM**
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